Royal Derby Hospital

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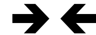
Ratings

Overall rating for this hospital	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Summary of findings

Overall summary of services at Royal Derby Hospital

Good 

We carried out a short notice announced focused inspection at Royal Derby Hospital on 30 July 2020. During the inspection, we inspected falls assessment and management across both the medicine and surgery core services. This was in response to concerns which were initially raised following serious incidents that had happened at the trust.

We visited medical wards 306 and 311 and surgical wards 205 and 206. We spoke with 10 members of staff, including healthcare support workers, nurses including manager grade and therapy staff. We did not speak with any patients. We reviewed 14 patient records and observed staff providing direct care to patients.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. However, the ratings for safe (in medicine and surgery services), effective (in surgery services) and therefore surgery services overall went down. We rated these areas as requires improvement. Please refer to the 'areas for improvement' section for more details.

We found:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients and acted on them.
- The service controlled infection risk and managed safety incidents well.
- Staff provided good care and treatment. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to information.
- Staff took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Staff were focused on the needs of patients receiving care and were clear about their roles and accountabilities.

However, we also found:

- There were inconsistences in falls risk assessments being completed and their outcomes. In two patients' records we reviewed, their falls risk assessments showed they were at risk of falls based on the assessment score, but the outcome recorded did not match and the patients were recorded as not being at risk of falls.
- Falls risk assessments were not always completed on admission in line with trust guidance.
- Patients who required vision assessments did not always have one completed and documented in their records.
- Falls care plans were not always updated following a fall on the ward, despite the foreword on the care plan document stating it must be reviewed post fall. Staff did not always follow bed rail risk assessments when using bedrails, and the reason for deviation from recommendations was not always documented
- Mandatory training compliance, specifically modules related to falls prevention and safeguarding training did not comply with trust targets. Data provided by the trust showed poor compliance on all wards we visited.

Summary of findings

- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty. There was poor mitigation of risks following falls as not all staff were aware of learning from incidents.

Medical care (including older people's care)

Good

Summary of this service

Our overall rating of this service stayed the same.

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients and acted on them. The service controlled infection risk and managed safety incidents well.
- Staff provided good care and treatment Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Staff were focused on the needs of patients receiving care and were clear about their roles and accountabilities.

However:

- Governance processes were inconsistent and not all staff received updates and information, and lessons learned from incidents were not always shared.
- Not all staff had received training in key skills in line with the trust's target.
- Some patient records were not always up-to-date with the rationale not always documented.

Is the service safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- While managers investigated incidents, not all staff received lessons learned which were shared with the whole team and the wider service.
- Some records were not always up-to-date with rationale for the decisions made not always documented.
- Not all patients at risk of falls were supervised according to the trust policy.
- Not all staff were trained to use the equipment or to safely mobilise patients.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for most patients and removed or minimised most risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Medical care (including older people's care)

- Staff mostly kept detailed records of patients' care and treatment, which were easily available to all staff providing care and stored securely.
- Staff recognised incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Our rating of effective stayed the same.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- The service made sure staff were competent for their roles.

However:

- Not all staff had completed all required training in line with the trust's training target to ensure that they were competent for their roles.

Is the service responsive?

Good

Our rating of responsive stayed the same.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

However:

- Not all wards were designed to meet the needs of patients living with dementia.

Is the service well-led?

Good

Our rating of well-led stayed the same.

- Governance processes were not yet consistent across the wards. Not all staff received updates and information, and most were unaware of quality improvement initiatives.
- Many actions taken to reduce falls had not been embedded, with some delayed due to COVID-19.

However:

- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service did not always make sure all staff completed mandatory training in key skills.

While staff were experienced and qualified, not all had received and kept up-to-date with their mandatory training. The trust had 32 mandatory training modules which included dementia awareness, falls prevention, patient handling, safeguarding levels 1 and 3, and infection control levels 1 and 3. Not all of them were applicable to all staff. We reviewed seven modules which were applicable to the focus of this inspection. Data provided by the trust following our inspection of wards 306 and 311 showed that the 95% trust target was only met for three of the seven mandatory training modules we reviewed for July 2020 We also requested training data for February 2020 to assess the impact of COVID-19 on staff training, however this was not provided. Across all seven modules, the data provided showed an overall compliance of 84.6% on wards 306 and 311. However, there was significant variability in compliance between modules and wards.

Training compliance on ward 306 across the seven modules was 81.6%. The trust’s compliance target of 95% was met by the ward in relation to dementia awareness, safeguarding level 1 and infection control level 1. The remaining four modules were all below the trust’s target, with some significantly worse. Infection control level 3 training compliance was 81.6%, falls prevention was 79% compliant, and patient handling was significantly below the trust target with 57.9% compliance.

Training compliance on ward 311 across the seven modules was 87.6%, The trust’s compliance target of 95% was met by the ward in relation to dementia awareness, safeguarding level 1 and infection control level 1. The remaining four modules were all below the trust’s target, with some significantly worse. Infection control level 3 training compliance was 89.1%, and patient handling and falls prevention were significantly below the trust target with 71.7% and 69.6 compliance respectively. While compliance was low, staff we spoke with on wards 306 and 311 had good knowledge around patient handling and falls prevention.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia which were included as part of the safeguarding training. There was also a standalone training module for dementia.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust had three safeguarding levels of training for nursing staff which were mandatory, however data provided by the trust following our inspection, showed staff either completed safeguarding level 1 and/or level 3, with no recorded competencies for level 2. Staff on ward 306 and 311 met the 95% trust target for safeguarding level 1 with an overall compliance of 95.4%. However, overall compliance for safeguarding level 3 was lower at 73.5%. The was also significant variation between the wards, with staff on ward 306 being 57.9% compliant, while on ward 311, 89.1% of staff were compliant for safeguarding level 3. We noted that across both wards, no staff were identified as being eligible for consent training, except for doctors and advanced clinical practitioners as this module outlines the principles and law of consent. Staff we spoke with on wards 306 and 311 had good knowledge around safeguarding and told us there had been no recent safeguarding issues or concerns.

Following our inspection, the trust stated that in November 2019 they had expanded the target audience for safeguarding level 3 to include staff who had previously only been required to do level 2. This change meant staff trained to level 2 would be recorded as compliant/non-complaint for safeguarding level 3 dependent on whether they had completed their level 3 training. Information provided by the trust stated that level 2 compliance before the expansion was 93 to 96%. However, as stated above, overall compliance for safeguarding level 3 was 73.5%, which was below the trust target of 95%.

Staff told us regular mandatory training updates were completed depending on training requirements. Staff could access mandatory training in a variety of ways and included online e-learning and face-to-face sessions as appropriate. Staff were allocated dedicated time to complete 'face to face' mandatory training. Training was completed and entered onto the trust's electronic system where competences achieved following training could then be awarded. Staff reported that most training had been delivered via e-learning as some face-to-face sessions were cancelled due to COVID-19.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. All ward areas we visited were seen to be visibly clean and tidy. During our inspection we found the general cleaning of the environment and furnishings in all ward areas was consistently of a high standard.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff received training about infection prevention and control (IPC) and hand hygiene during their trust induction and annual mandatory training. Following our inspection, data provided by the trust showed as of July 2020, 85.4% of nursing staff had completed Infection Control Level 3 training. This was below the trust target of 95%, however 99% of nursing staff had completed Infection Control Level 1.

We saw most staff using either hand gel or washing their hands at the appropriate time. We saw staff follow infection control practices. This included wearing the correct personal protective equipment (PPE), such as masks, gloves and aprons. We saw staff wearing gloves and aprons for all patient contact, which were discarded and replaced between each patient. Staff routinely sanitised their hands using either hand gel or handwashing facilities.

Clinical staff adhered to the trust's being bare below the elbows policy. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from staff who wear gloves or decontaminate their hands immediately before and after every episode of direct contact or care.

Handwashing facilities were appropriate and accessible. Hand hygiene gels were available for use at each entrance and throughout the ward, and there was hand hygiene advice displayed on the walls, which reminded staff, visitors, and patients to decontaminate their hands prior to entry. Appropriate PPE, such as masks, gloves and aprons were readily available for staff to use.

Staff cleaned equipment after patient contact. We saw staff cleaning equipment at the start of the day and between patients. There was no evidence of high level dust. Staff told us they would always clean equipment before and after use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, not all staff were trained to use the equipment or to safely mobilise patients.

The service had enough suitable equipment to help them to safely care for patients, however not all staff had received or were up-to-date with training on how to safely operate equipment or mobilise patients safely. Staff told us they had sufficient equipment to meet patient's needs, and there were not usually any problems or delays in getting access to more specialist equipment.

Staff had access to mobility aids such as Zimmer frames and walking sticks which were adjustable and tailored for use by specific patients. While patients were assessed for and prescribed their own walking aids, staff told us that some patients living with dementia or other cognitive impairments would swap equipment, despite being labelled with the patients name. Staff told us that patients did not have to share mobility aids, and if patients were required to be discharged with mobility aids, they would be ordered and sent home with them.

Staff had access to suitable equipment to support their patients' mobility needs while on the ward, including hoists and an air patient lift. The air patient lift was a piece of equipment used to safely lift and transport patients in a comfortable and dignified manner. In the event of a patient fall, the inflatable mattress type equipment would inflate to gently lift the patient from the floor onto a bed or trolley in a flat lying position, therefore preventing further pain or injury.

Not all staff received training on how to safely operate and use equipment related to patient handling. Following our inspection, data provided by the trust showed as of July 2020, 64.8% of staff on wards 306 and 311 had completed patient handling training. This was significantly below the trust target of 95%. Staff told us this training was normally delivered by e-learning.

Practical training sessions and workshops for training on specialist falls equipment such as the air patient lift had been suspended due to COVID-19. In these practical sessions, staff were able to learn how to operate equipment and also what it felt like for patients. For some of the specialist equipment including the air patient lift, training was delivered by the clinical educator. Staff were assessed to check their competency when operating equipment following their training.,

Staff understood the importance of appropriate footwear. All patients we observed were wearing sturdy slippers or anti-slip socks to minimise the risk of a fall.

Patients could reach call bells. There were call alarms situated above each patient bed within the ward areas and staff were aware of the need for additional supervision for patients living with dementia or other cognitive impairments who may not understand the need for, or how to use call bells.

Assessing and responding to patient risk

Staff completed and updated risk assessments for most patients and removed or minimised most risks. Most patients at risk of falls were supervised according to the trust policy.

Staff completed risk assessments for most patients on admission to each ward and generally updated them when necessary. However, we found evidence some assessments were not completed in line with trust policy. Staff used national recognised tools to assess patient's risk of developing for example, pressure ulcers and nutritional risks. They also used a multi-factorial falls risk assessment to identify each patient's risk of falls and any associated risks with moving and handling. We saw these risk assessments were reviewed regularly and when patients moved wards or had a change in condition, they were reassessed. The falls risk assessment covered any cognitive, visual or mobility impairments, continence, falls history, medication they were taking and other health problems which may lead to an increased risk of falls. On completion of the risk assessment, patients were either deemed a falls risk and placed on a falls care plan, or not immediately at risk of falls and would be reassessed if their condition changed.

During our inspection we reviewed eight patient records on wards 306 and 311 and found a falls risk assessment had been completed for all patients, and care plans were in place for those patients who were deemed a falls risk. However, we found inconsistences in assessments being completed and their outcomes. In two patients' records we reviewed, their falls risk assessments showed they were at risk of falls based on the assessment score, but the outcome recorded

did not match and the patients were recorded as not being at risk of falls. Despite these issues, falls care plans were subsequently put in place. We also found one falls risk assessment had not been completed on admission, which was not in line with trust guidance. One patient was identified as requiring a vision assessment; however, this was not documented in the patients record. In one patient's record we found a care plan had not been updated following a fall on the ward, despite the documentation clearly stating it must be reviewed post fall.

Staff undertook daily assessments for bed rail suitability where it was considered that bed rails may be useful. During the inspection, we saw that bed rails were used following an appropriate assessment, which indicated bedrails would support a patient to safely remain in bed rather than rolling out. However, in two out of the eight patients records we reviewed, the risk assessment did not recommend their use, but they were documented as being in use with no reason provided.

Staff knew about and dealt with any specific risk issues. Staff were aware of the risk factors that increased the likelihood and contributed to falls and could give examples such as confusion or delirium, vision impairment, low blood pressure and inadequate footwear. Staff told us what types of interventions or planned care could be used to mitigate and limit these risk factors to reduce the chance of a fall. For example, the use of mobility aids, keeping their toenails short, suitable footwear and supervising patients either one-to-one or as a cohort group.

During our inspection, we saw patients who were on one-to-one supervision and patients who were being supervised as a cohort to prevent falls. We observed there was always a member of staff in each bay, and when performing supervision, staff told us they were not allowed to leave unless they were covered by another member of staff. To ensure there was always someone on supervision during the day, the wards implemented a 'pass the baton' system. The baton was represented by a card which was held by the supervising member of staff, and when leaving the bay, it was passed on and given to the staff member that was then supervising. We did not see any examples of where a member of staff in a bay would attend to a patient behind a closed curtain as part of a cohort, however staff told us they would request assistance from another member of staff to ensure patients were always under supervision. Staff understanding of supervising patients in a bay where at least one patient was a risk of falls, was consistent across all wards. They were expected to remain unless they 'passed the baton' and were relieved by another member of staff. Staff gave an example of when a patient had a cardiac arrest on the other side of the ward and they remained in their assigned bay in order to protect the patients they were supervising.

However, in one patient record we reviewed, we identified a patient who had recently had an unwitnessed fall on the ward while in a cohort bay under supervision. The fall was unwitnessed on moving from sitting to standing, and staff were unable to explain why this patient and the rest of their cohort were not under supervision at the time of their fall. Their personal handling plan stated they were not independent on sit to stand two days prior to their fall but were recorded as independent on the day. We also found their falls care plan had not been updated following their fall, despite the documentation clearly stating it must be reviewed post fall.

Following our inspection, the trust provided us with a copy of their enhanced nursing policy, which at the time of our inspection was out of date and was due for review in 2018. The policy contained information on patient supervision and monitoring patients at risk of falls, and stated that when supervising patients, nursing staff should not be assigned more than four patients in a cohort for close supervision and they should be within eyesight of staff at all times. Staff used a risk assessment with suggested levels of supervision ranging from one-to-one continuous supervision to support with intentional rounding which we found was completed regularly.

The trust had an enhanced care team which could provide one-to-one support for patients at high risk of falls. Staff told us additional staff were authorised for patients who required one-to-one supervision, and that ward acuity including supervision requirements was escalated to ensure they had access to additional staff if required.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Medical staff assessed patient's mental health and made recommendations where appropriate.

Staff shared key information to keep patients safe when handing over their care to others, and shift changes and handovers included all necessary key information to keep patients safe. Nursing staff had daily handovers and ward rounds to discuss each patients' needs. Staff highlighted staffing and workload issues, patients due for discharge and patients who were cohorting or required supervision. This ensured staff were continually updated on the plan of care for every patient on the ward and the nurse in charge maintained an effective oversight of the patients in their care. Staff told us they knew which patients were at risk of falls in each area and used an eye icon on the patient whiteboard to indicate they were under supervision.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing staff and support staff to keep patients safe, and the number of nurses and healthcare assistants matched the planned numbers. Data provided by the trust following our inspection showed staffing levels were appropriate to deliver safe care and treatment to patients. Most staff we spoke with did not have any concerns about nursing staff levels, and the wards we visited were visibly calm and well managed during our inspection. Staff told us almost all established posts were filled and that they were going out to recruitment for additional posts. However, some staff were concerned that a combination of COVID-19 and seasonal flu may have an impact on staffing levels across the wards. One staff member told us they were worried about staffing the ward safely for the first time ever over the winter period for this reason.

From July to August 2020, during the day shift the number of nurses matched or exceeded the planned numbers on wards 306 and 311 with an average fill rate of 124.4%. However, during the night shift, the fill rate dropped slightly below the planned numbers with an average of 99.1%. On ward 306 the fill rate for the day shift was 144% while the night shift was 98.9%. On ward 311 the fill rate for the day shift was 104.7 % while the night shift was 99.3%.

During the same period from July to August 2020, the day and night shift fill rate of healthcare assistants and other unregistered staff varied between wards 306 and 311. On ward 306 the fill rate for the day shift was 93.8% while the night shift was 180.6%. On ward 311 the fill rate for the day shift was 102% while the night shift was 99.9%.

The ward manager could adjust staffing levels according to the needs of patients. Staff told us that if additional staff were required, for example to support one-to-one supervision of a patient, it was escalated to the ward sisters for authorisation. In other instances where the ward was short staffed and additional staff could not be redeployed to the ward, staff told us the ward sisters worked clinically to support staff. Staff also told us the team were flexible and changed their shifts to cover staff shortages.

Records

Staff mostly kept detailed records of patients' care and treatment, which were easily available to all staff providing care and stored securely. However, some supervision requirements and bed rail assessments were not always up-to-date with the rationale for decisions made not always documented.

Patient notes were comprehensive, and all staff could access them easily. The majority of records were paper based. However, the trust recorded a range of information on its electronic patient record (EPR) system. Patient demographic details (such as name, date of birth and address), referrals and blood and diagnostic tests were stored electronically. We

reviewed eight patient records and found they were clearly written and legible. Records were up-to-date and available to all staff providing care with all entries, dated, timed, signed and the designation of the person making the entry identified. Admission records and nursing assessments were legibly documented in keeping with national Record Keeping Guidelines.

Records contained where appropriate details of patient's mental health, learning disability and dementia needs. Two of the records we reviewed had a 'getting to know me' sheet completed in detail. This included their likes and dislikes, their background, what they liked to be called, the important people or places in the person's life and what helped them relax. Another patient record we reviewed had a learning disability hospital passport.

All eight records we reviewed had an falls risk assessment completed which included; cognitive impairment discussion, continence, falls history, footwear/feet, health problems, medications, mobility/instability, syncope/postural hypotension and visual/sensory impairment. All eight records also had a falls care plan in place. However, in one patient's record we found that supervision requirements were not recorded on the day of their fall on the ward, despite this information being documented on days pre and post their fall.

Bed rail assessments were completed in six of the eight records we reviewed, with patient wishes documented in the assessments. In two of the records reviewed, the risk assessment did not recommend their use however they were documented as being in use with no rationale provided. Staff told us that bed rails were often used on request of the patient, even if this was against the recommendation of the risk assessment. Staff told us they would record in the patients record. Standard personal handling plans were completed in all of the records we reviewed, which detailed the number of staff required and what equipment to assist with handling.

Two of the records we reviewed had a frail elderly assessment. This included discussions with family, and assessed home situation, mobility, transfers, activities of daily living, cognition/psychological.

Records were stored securely. Patients' medical and nursing records were centrally stored on site. On admission, patients' records were requested and stored securely in lockable trolleys either in corridors or store cupboards on the ward. During our inspection, we saw no notes trolleys left unattended when unlocked. We also saw that no patient identifiable data was left unattended or in public view and computers were locked when not in use. Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual account log-in details. Staff received training on information governance as part of their mandatory training programme which was up-to-date.

When patients transferred to a new ward, there were no delays in staff accessing their records.

Incidents

While managers investigated incidents, not all staff were made aware of the lessons learned. However, staff recognised incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff throughout the wards we visited described the process for reporting incidents and were confident in using the system.

However, not all staff received feedback from investigation of incidents, both internal and external to the service. Ward managers and sisters we spoke with, told us incident investigations and learning from falls was shared with staff via email bulletins, and was discussed at daily huddles and at handover. Staff told us conflicting information and said learning was not normally shared, with almost all staff we spoke with unaware of any incidents across the trust or on other wards which might have resulted in learning. We asked staff on ward 306 about a recent fall that occurred on the ward and some were unaware of the incident.

There was limited evidence that changes had been made as a result of feedback. When asked, staff were unable to give any examples of any learning from incidents in the past 12 months. One exception was that following falls on ward 306, the trust included vision assessments as part of the wider falls assessment. Following our inspection, we asked the trust to provide examples of shared learning, however nothing was provided in relation to the wards we visited.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reason able support to the person. Staff said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. Staff were familiar with the terminology used to describe their responsibilities regarding the duty of candour regulation. Staff described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the patient and their relatives.

Is the service effective?

Competent staff

The service made sure staff were competent for their roles.

The clinical educators supported the learning and development needs of staff. Staff told us there was an emphasis on falls training, and that some face to face training had been delivered in 2020 in addition to the mandatory e-learning training. For some of the specialist equipment including the air patient lift, training was delivered by the clinical educator. Staff were assessed to check their competency when operating equipment following their training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us team meetings for all ward were held quarterly, and that full notes were made available for those who could not attend. Following our inspection, we requested copies of team meeting minutes, however these were not received.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. All staff were expected to complete mandatory training modules, and compliance was monitored by managers. Staff told us their training and development needs were discussed at their annual appraisal, and they confirmed they had been assessed to ensure they were competent in their role. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education by their manager.

Staff told us they had undertaken training on falls management, manual handling, dementia awareness and mental capacity whilst at the trust. Staff new to the trust completed this as part of induction training whereas longer serving staff undertook refresher training. Staff reported that the majority of this training was electronic; however, some modules were delivered face to face.

Multidisciplinary Working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical care (including older people’s care)

Staff worked across health care disciplines and with other agencies when required to care for patients. During our inspection we observed staff including physiotherapists, occupational therapists and members of the Frail and Elderly Assessment Team (FEAT) work closely with ward staff to provide treatment and support. The therapists, and on the short stay ward the FEAT team, collaborated on falls risk assessments with ward staff and were involved in daily handover meetings.

A trust falls group, which was made up of a multi-disciplinary team, worked across the trust to develop consistency in working practices, to review falls incidents and provide support and to conduct analysis of falls to promote learning. Very few staff we spoke with were aware of the falls group and what they did and were unable to give any examples of sharing learning around falls prevention.

Staff referred patients for mental health assessments when they showed signs of mental ill health, for example depression. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They undertook mental capacity assessments in line with the Mental Capacity Act. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, not all staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards

Staff gained consent from patients for their care and treatment in line with legislation and guidance, and clearly recorded consent in the patients’ records. During our inspection, we observed staff gaining verbal consent when they undertook routine tasks such as administering medicines, taking bloods, shutting curtains around the bed and when delivering therapy. Staff told us they routinely took consent and provided patients with information and answered any questions they may have.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with had a good understanding of the need to assess patient’s capacity to make decisions when necessary. We saw completed ‘Respect’ forms which indicated decisions about cardio-pulmonary resuscitation or other lifesaving treatment at the end of a patients’ life had been discussed. Staff were aware of how to implement Deprivation of Liberty Safeguards (DOLS) in line with trust guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff were able to explain the best interests’ decision-making process. They gave examples of when it was recognised that patients needed extra support when consenting to treatment, such as when patients had a learning disability or were living with dementia. Staff told us they involved the patient’s relatives and carers to provide further information about the patient’s wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient. Where patient’s lacked capacity during completion of ‘respect’ forms, we saw capacity assessments were completed and discussions with family were detailed. Staff told us medical staff were responsible for completing mental capacity assessments. Senior nurses completed DOLS application forms electronically if required.

Is the service responsive?

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, not all wards were designed to meet the needs of patients living with dementia.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. During our inspection, we observed nursing and medical staff interacting with patients and undertaking ward rounds. While they discussed their physical health needs and conditions, they also reviewed their mental health needs and made adjustments where necessary.

Wards were not always designed to meet the needs of patients living with dementia. During our inspection, we found few environmental dementia friendly initiatives with the exception of care of the elderly wards, which had bays which were different colours. However, this was limited and we found no other adaptations. Staff told us that as patients would always be assisted to the toilets, there was no need to help identify them with brightly coloured doors for example.

Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name and if they were under supervision, an eye symbol was displayed.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. They enabled staff to provide individualised care to patients. We saw several of these fully completed during our inspection. Patient passports included information about patients' likes and dislikes, eating and drinking preferences, special requirements and personal information such as what the patient enjoyed doing in their spare time and information about their family and pets. Communication requirements and preferences were also documented.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust wide enhanced care team provided staff for one-to-one observation also included activity co-ordinators who could work with patients to provide distraction activities and reduce the risk of falls.

Staff had access to communication aids to help patients become partners in their care and treatment, and managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to appropriate translation services, and sign language interpreters when required. Staff had access to a telephone interpreter if they could not attend the ward at short notice. Staff told us they had not experienced any difficulties with accessing interpreters when they were needed.

Is the service well-led?

Governance

Governance processes were not yet consistent across the wards. Not all staff received updates and information and most were unaware of quality improvement initiatives. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers and leaders of the service described the systems and processes of accountability across the wards we visited. Staff understood their roles and what they were accountable for. Nursing staff told us they attended daily huddles to discuss patients most at risk, and we saw that information was available for staff to read across ward areas. This included a trust wide falls policy, which was in date and comprehensive. The trust also had an enhanced nursing policy, which at the time of our inspection was out of date and was due for review in 2018. The policy contained information on patient supervision and monitoring falls risk patients.

While staff told us they generally heard about complaints and audits, they were not aware of any incidents that had occurred on the ward or elsewhere across the trust. Staff were also not aware of any quality improvement initiatives. Senior nurses told us incident investigations and learning from falls was shared with staff via email bulletins and discussed at daily huddles and during handover. Similarly, senior nurses said information from the trust wide falls group

was shared during quarterly team meetings. This conflicted with information given to us by staff, who when asked were unable to give any examples of when a fall had occurred, including some staff on one ward we visited where a fall had happened two weeks prior to our inspection. Staff were also unable to give examples, with the exception of one staff member, of learning from falls and any changes made as a result.

Falls were monitored by the trust wide falls group and through regular audits. Following our inspection, the trust sent us a report presented at the patient safety committee, which monitored falls which had occurred across the trust between January and April 2020. Falls data was also included from the previous eight months (April 2019 to December 2019). Between April 2019 and April 2020, the number of falls across Royal Derby Hospital was above the trust target (five falls per 1000 bed days) for 11 of the 13 months reviewed, with a recent increase in the number of falls recorded in March and April 2020. The report also presented data on the number of falls with harm across the trust. At Royal Derby Hospital, the harm per 1000 bed days ranged between 0.096 and 0.215 which was below the target.

Several themes were identified in the trusts report in relation to seven reported falls with harm. These included most falls being unwitnessed, confusion in two patients, most of the patients that fell were mobilising, therefore did not fall from their beds, and the use of the inflatable device used to lift a patient after a fall was found to be inconsistent. Bed rails were not found to be a significant factor. It is acknowledged the trust falls group had not been able to meet as regularly and suspended meetings in March and April 2020 as part of the COVID-19 trust response.

Information provided by the trust showed various areas of continued improvement and development. These included a renewed focus on delivering falls training to all staff across the trust, a twice yearly falls conference, a 'falls week' to be held once a year, the development and using posters to promote falls awareness in clinical areas.

Management of risks, issues and performance

Many actions taken to reduce falls were in progress, with some delayed due to COVID-19. However, leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had arrangements for identifying, recording and manging risks, and staff had opportunities to learn from the performance of the service.

The trust falls group, which was made up of a multi-disciplinary team, worked across the trust to develop consistency in working practices and included staff from ward areas and the trusts leadership team. The group were undertaking trust wide quality improvement initiatives and we saw evidence to show that medication reviews and lying/ standing blood pressure were being explored for example. Following our inspection, we received the trust wide falls action plan to improve patient safety in relation to falls. The action plan included 18 actions grouped into themes such as policy and procedure, training and patient and staff information. We noted that few actions had been completed, with some delayed due to the COVID-19 pandemic.

The action plan included a number of measures aimed at addressing some of the concerns we found during our inspection. For example, data provided by the trust showed training compliance for several falls related mandatory training modules were below the trust's target of 95%, and in some cases significantly so. One action was to include falls compliance on the workforce dashboard for monitoring and for training reports to be reviewed by the falls group. Wards were also to be identified as priority to receive extra training.

Another action identified was to ensure 'falls heroes' were in place on each ward who would also be members of the falls group. During our inspection, none of the wards we visited had falls champions or individuals who were part of the falls group. However, the action plan showed this was still outstanding.

One action included falls conferences to be held twice a year and a 'falls week' to run annually on each site to raise awareness about falls. Staff told us events scheduled for March 2020 were cancelled and were due to be rearranged.

Medical care (including older people’s care)

Senior nurses told us they undertook spot checks of falls assessments, care plans, bed rails and falls checklists. Senior nurses conducted audits to monitor compliance with falls prevention standards.

Serious incidents involving falls with harm were discussed at the patient safety group meetings via information presented by the falls group. Areas for improvement and ideas to maintain consistency across the trust were also discussed.

Areas for improvement

The trust must:

Ensure that learning following incidents is shared with all staff. Health and Social Care Act (2014) Regulation 12: Safe care and treatment

The trust should:

Ensure mandatory training compliance meets the trust target.

Ensure that all staff receive training to safely operate specialist equipment safely.

Ensure all relevant staff receive consistent information regarding falls management.

Ensure patient records and assessments are always up-to-date with rationale for decisions clearly documented.

Ensure that ward environments are more friendly for patients living with dementia.

Ensure policies and procedures are in date and regularly reviewed.

Surgery

Requires improvement

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

- Not all staff had received training in key skills in line with the trust's target.
- Lessons learned from incidents were not always shared with staff.
- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act.
- Governance processes were inconsistent and not all staff received updates and information.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients and acted on them. The service controlled infection risk and managed safety incidents well.
- Staff provided good care and treatment. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff were focused on the needs of patients receiving care and were clear about their roles and accountabilities.

Is the service safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- Not all staff had received training in key skills in line with the trust's target.
- Not all staff were trained to safely mobilise patients and safely operate and use equipment related to patient handling.
- While managers investigated incidents, not all staff received lessons learned which were shared with the whole team and the wider service.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Surgery

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Staff recognised incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement

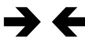
Our rating of effective went down. We rated it as requires improvement because:

- Staff did not always undertake mental capacity assessments in line with the Mental Capacity Act.

Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty. However:

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- She service made sure staff were competent for their roles.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

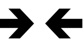
Is the service responsive?

Good 

Our rating of responsive stayed the same.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Is the service well-led?

Good 

Our rating of well-led stayed the same.

- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

However:

- Governance processes were not yet consistent across the wards. Not all staff received updates and information following incidents and most were unaware of quality improvement initiatives.
- Many actions taken to reduce falls were in progress, with some delayed due to COVID-19.

Surgery

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service did not always make sure all staff completed mandatory training in key skills.

While staff were experienced and qualified, not all had received and kept up-to-date with their mandatory training. Seven mandatory training modules were related to the focus of this inspection and included dementia awareness, falls prevention, patient handling, safeguarding levels 1 and 3, and infection control levels 1 and 3. Not all of them were applicable to all staff. Data provided by the trust following our inspection of wards 205 and 206 showed that the 95% trust target was meet for two of the seven mandatory training modules we reviewed for July 2020. We also requested training data for February 2020 to assess the impact of COVID-19 on staff training, however this was not provided. Across all seven modules, the data provided showed an overall compliance of 87.3% on wards 205 and 206, however there was significant variability in compliance between modules and wards.

Training compliance on ward 205 across the seven modules was 79.7%, with the trust compliance of 95% met by dementia awareness and infection control level 1. The remaining five modules were all below the trust target, with some being significantly worse. Infection control level 3 training compliance was 69.1%, and patient handling and falls prevention were significantly below the trust target with 59.2% and 64.3% compliance respectively.

Training compliance on ward 206 was 95% across the seven modules, with the trust compliance of 95% met by dementia awareness, safeguarding level 1 and 3 and infection control level 1. The remaining three modules were all below the trust target. Infection control level 3 training compliance was 91.4%, and patient handling and falls were below the trust target with 91.2% and 82.4 compliance respectively. While compliance was low, staff we spoke to on wards 205 and 206 had good knowledge around patient handling and falls prevention.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia which were included as part of the safeguarding training. There was also a standalone training module for dementia.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust had three safeguarding levels of training for nursing staff which were mandatory, however data provided by the trust following our inspection, showed that staff either competed safeguarding level 1 and/or level 3, with no recorded competencies for level 2. Staff on ward 205 and 206 met the 95% trust target for safeguarding level 1 with an overall compliance of 95.5%. However, overall compliance for safeguarding level 3 was lower at 86.9%. The was significant variation between the wards, with staff on ward 205 being 73.8% compliant, while all staff on ward 206 were compliant for safeguarding level 3. We noted that across both wards, no staff were identified as being eligible for consent training, except for doctors and advanced clinical practitioners as this module outlines the principles and law of consent. Staff we spoke to on wards 205 and 206 had good knowledge around safeguarding and told us there had been no recent safeguarding issues or concerns.

Following our inspection, the trust stated that in November 2019 they had expanded the target audience for safeguarding level 3 to include staff who had previously only been required to do level 2. This change meant staff trained to level 2 would be recorded as compliant/non-complaint for safeguarding level 3 dependent on whether they had completed their level 3 training. Information provided by the trust stated that level 2 compliance before the expansion was 93 to96%. However, as stated above, overall compliance for safeguarding level 3 was 86.9%, which was below the trust target of 95%.

Staff told us regular mandatory training updates were completed depending on training requirements. Staff could access mandatory training in a variety of ways and included online e-learning and face-to-face sessions as appropriate. Staff were allocated dedicated time to complete 'face to face' mandatory training. Training was completed and entered onto the trust's electronic system where competences achieved following training could then be awarded. Staff reported that most training had been delivered via e-learning as some face to face sessions cancelled due to COVID-19.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. All ward areas we visited were seen to be visibly clean and tidy. During our inspection, we found the general cleaning of the environment and furnishings in all ward areas was consistently of a high standard.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff received training about infection prevention and control (IPC) and hand hygiene during their trust induction and annual mandatory training. Following our inspection, data provided by the trust showed as of July 2020, 80.2% of nursing staff had completed Infection Control Level 3 training. This as below the trust target of 95%, however all nursing staff had completed Infection Control Level 1. We saw most staff using either hand gel or washing their hands at the appropriate time. We saw staff follow infection control practices. This included wearing the correct personal protective equipment (PPE), such as masks, gloves and aprons. We saw staff wearing gloves and aprons for all patient contact, which were discarded and replaced between each patient. Staff routinely sanitised their hands using either hand gel or handwashing facilities. Clinical staff adhered to the trust's being bare below the elbows policy. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from staff who wear gloves or decontaminate their hands immediately before and after every episode of direct contact or care. Handwashing facilities were appropriate and accessible. Hand hygiene gels were available for use at each entrance and throughout the ward, and there was hand hygiene advice displayed on the walls, which reminded staff, visitors, and patients to decontaminate their hands prior to entry. Appropriate PPE, such as masks, gloves and aprons were readily available for staff to use.

Staff cleaned equipment after patient contact. We saw staff cleaning equipment at the start of the day and between patients. There was no evidence of high level dust. Staff told us they would always clean equipment before and after use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, not all staff were trained to use the equipment or to safely mobilise patients.

The service had enough suitable equipment to help them to safely care for patients. However not all staff had received or were up-to-date with training on how to safely operate equipment or mobilise patients safely. Staff told us they had sufficient equipment to meet patient's needs, and there was usually no problems or delays in getting access to more specialist equipment. Staff had access to mobility aids such as Zimmer frames and walking sticks which were adjustable and tailored for use by specific patients. While patients were assessed for and prescribed their own walking aids, staff told us that some patients living with dementia or other cognitive impairments would swap equipment, despite being labelled with the patients name. Staff told us that patients did not have to share mobility aids, and if patients were required to be discharge with mobility aids, they would be ordered and sent home with them.

Staff also had access to suitable equipment to support patients mobility needs while on the ward, including hoists and an air patient lift. The air patient lift was a piece of equipment used to safely lift and transport patients in a comfortable and dignified manner. In the event of a patient fall, the inflatable mattress type equipment would inflate to gently lift the patient from the floor onto a bed or trolley in a flat lying position, therefore preventing further pain or injury.

Not all staff received training on how to safely operate and use equipment related to patient handling. Following our inspection, data provided by the trust showed as of July 2020, 75.4% of staff on wards 205 and 206 had completed patient handling training. This was below the trust target of 95%. Staff told us this training was normally delivered by e learning.

Practical training sessions and workshops for training on specialist falls equipment such as the air patient lift had been suspended due to COVID-19. In these practical sessions, staff were able to learn how to operate equipment and also what it felt like for patients. For some of the specialist equipment including the air patient lift, training was delivered by the clinical educator. Staff were assessed to check their competency when operating equipment following their training. Following our inspection, data provided by the trust showed as of July 2020, 73.6% of staff on wards 205 and 206 had completed training on the air patient lift.

Staff understood the importance of appropriate footwear. All patients we observed were wearing sturdy slippers or anti-slip socks to minimise the risk of falling.

Patients could reach call bells. There were call alarms situated above each patient bed within the ward areas and staff were aware of the need for additional supervision for patients with dementia or other cognitive impairments who may not understand the need for, or how to use call bells.

Assessing and responding to patient risk

Staff completed and updated risk assessments for most patient and removed or minimised risks.

Staff completed risk assessments for most patients on admission to each ward and generally updated them when necessary. Staff used nationally recognised tools to assess patients risk of developing for example, pressure ulcers and nutritional risks. They also used a multi-factorial falls risk assessment to identify each patients' risk of falls and any associated risks with moving and handling. We saw these risk assessments were reviewed regularly and when patients moved wards or had a change in condition, they were reassessed. The falls risk assessment covered any cognitive, visual or mobility impairments, continence, falls history, medication they were taking and other health problems which may lead to an increased risk of falls. On completion of the risk assessment, patients were either deemed at risk of falls and placed on a falls care plan, or not immediately at risk of falls and would be reassessed if their condition changed or on a weekly basis.

During our inspection, we reviewed four patient records and found a falls risk assessment had been completed for all patients, and care plans was in place for those patients that were deemed a falls risk.

Staff undertook daily assessments for bed rail suitability where it was considered that bed rails may be useful. During the inspection, we saw that bed rails were used following an appropriate assessment that indicated bedrails would support a patient to safely remain in bed rather than rolling out.

Staff knew about and dealt with any specific risk issues. Staff were aware of the risk factors which increased the likelihood and contributed to falls and could give examples such as confusion or delirium, vision impairment, low blood pressure and inadequate footwear. Staff told us what types of interventions or planned care could be used to mitigate and limit these risk factors to reduce the chance of a fall. For example, the use of mobility aids, keeping patients toenails short, suitable footwear and supervising patients either one-to-one or as a cohort group.

During our inspection, we saw patients who were on one-to-one supervision and patients who were being supervised as a cohort to prevent falls. We observed there was always a member of staff in each bay, and when performing

supervision, staff told us they were not allowed to leave unless they were covered by another member of staff. We did not see any examples where a member of staff in a bay would attend to a patient behind a closed curtain as part of a cohort, however staff told us they would request assistance from another member of staff to ensure patients were always under supervision. Staff understanding of supervising patients in a bay where at least one patient was a risk of falls, was consistent across all wards and were expected to remain unless they 'passed the baton' and were relieved by another member of staff.

Following our inspection, the trust provided us with a copy of their enhanced nursing policy, which at the time of our inspection was out of date and was due for review in 2018. The policy contained information on patient supervision and monitoring falls risk patients, and stated that when supervising patients, nursing staff should not be assigned more than four patients in a cohort for close supervision and they should always be within eyesight of staff. The policy also contained a risk matrix which should be completed for all patients and the score recorded on care records to identify what level of supervision each patient required. During our inspection, we did not see this assessment score recorded. Staff instead used a risk assessment with suggested levels of supervision ranging from one-to-one continuous supervision to support with intentional rounding.

The trust had an enhanced care team that could provide one-to-one support for patients at high risk of falls. Staff told us additional staff were authorised for supervising patients who required one-to-one care, and that ward acuity including supervision requirements was escalated to ensure they had access to additional staff if required.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Medical staff assessed patients' mental health and made recommendations where appropriate.

Staff shared key information to keep patients safe when handing over their care to others, and shift changes and handovers included all necessary key information. Nursing staff had daily handovers and ward rounds to discuss each patients' needs. Staff highlighted staffing and workload issues, patients due for discharge and patients who were cohorted or required supervision. This ensured staff were continually updated on the plan of care for every patient on the ward and the nurse in charge maintained an effective oversight of the patients in their care. Staff told us they knew which patients were at risk of falls in each area and used an eye icon on the patient whiteboard to indicate they were under supervision.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing staff and support staff to keep patients safe, and the number of nurses and healthcare assistants matched planned numbers. Data initially provided by the trust showed that staffing did not match the planned numbers, with fill rates between July and August 2020 on wards 205 and 206 frequently below 75%. However, this information was based on pre-COVID-19 activity and did not take into account that during the peak of the COVID-19 pandemic many wards were closed across the hospital with staff reallocated. Due to frequent staff moves, staffing fill rates were not updated. The trust subsequently provided staffing levels for July 2020 on wards 205 and 206 which showed staffing levels were appropriate to deliver safe care and treatment to patients.

In July 2020, during the early, late and night shifts the number of nurses was either just below or above the planned numbers on ward 205. The fill rate for the early shift was 94.2%, the late was 116.9% and the night shift was 95.7%. On ward 206 however, the fill rate for nurses was below the planned numbers with a 75.3% fill rate for the early shift, 72.0% for late and 67.7% for the night shift. While actual staffing numbers did not meet planned levels; during July 2020 the average bed occupancy rate was 22.1% and therefore had safe staffing levels for the number of patients.

During the same period in July 2020, the early, late and night shift fill rate for healthcare assistants and other unregistered staff was above the planned numbers on ward 205. The fill rate for the early shift was 113.3%, the late was 108.1% and the night shift was 147.1%. On ward 206 however, the fill rate for healthcare assistants and other unregistered staff was below the planned numbers with a 78.5% fill rate for the early shift, 74.2% for late and 12.9% for the night shift. As mentioned above with nursing staff on ward 206, while actual staffing numbers did not meet planned levels, during July 2020 the average bed occupancy rate was 22.1% and therefore had safe staffing levels for the number of patients.

Staff told us they were concerned about nursing and health care assistant staffing, especially during the night shift. This was due to the acuity of patients who were being supervised in cohort bays. Some staff believed patients were at risk, while other staff we spoke to said that staffing has been better in recent months. During our inspection, the wards we visited were visibly calm, not filled to capacity with patients and well managed.

The ward manager could adjust staffing levels according to the needs of patients. Staff told us that if additional staff were required, for example to support one-to-one supervision of a patient, it was escalated to the ward sisters for authorisation and bank or agency staff were requested to provide this cover. When this request was not met, ward staff were used which staff told us impacted the overall staffing for the ward. In other instances where the ward was short staffed and additional staff could not be redeployed to the ward, staff told us the ward sisters worked clinically to support staff. Staff also told us that the team were flexible and changed their shifts to cover staff shortages.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The majority of records were paper based; however, the trust recorded a range of information on its electronic patient record (EPR) system. Patient demographic details (such as name, date of birth and address), referrals and blood and diagnostic tests were stored electronically. We reviewed four patient records and found they were written clearly and legible. Records were up-to-date and available to all staff providing care with all entries, dated, timed, signed and the designation of the person making the entry identified. Admission records and nursing assessments were legibly documented in keeping with national Record Keeping Guidelines.

Records contained where appropriate details of patient's mental health, learning disability and dementia needs. However, in one of the records we reviewed, there was no dementia passport present despite the patient having been noted as living with dementia.

All four records we reviewed had an falls risk assessment completed which included; cognitive impairment discussion, continence, falls history, footwear/feet, health problems, medications, mobility/instability, syncope/postural hypotension and visual/sensory impairment. All four records also had a falls care plan in place following their completed falls risk assessment.

Bed rail assessments were completed in all four records, with patient wishes included during these assessments. In three of the records reviewed, bed rails were used at the patients request, even when the risk assessment did not recommend their use. Standard personal handling plans were completed in all of the records we reviewed, which detailed the number of staff required and what equipment to assist with handling.

Records were stored securely. Patients' medical and nursing records were centrally stored on site. On admission, patients' records were requested and stored securely in lockable trolleys either in corridors or store cupboards on the ward. During our inspection we saw no notes trolleys left unattended when unlocked. We also saw that no patient

identifiable data was left unattended or in public view and computers were locked when not in use. Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual account log-in details. Staff received training on information governance as part of their mandatory training programme which was up-to-date.

When patients transferred to a new ward, there were no delays in staff accessing their records.

Incidents

While managers investigated incidents, not all staff were made aware of lessons learned which were shared with the whole team and the wider service. However, staff recognised incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff throughout the wards we visited described the process for reporting incidents and were confident in using the system.

However, not all staff received feedback from investigation of incidents, both internal and external to the service. Ward managers and sisters we spoke with, told us that incident investigations and learning from falls were shared with staff via email bulletins, and discussed at daily huddles and at handover. Staff told us conflicting information and said learning was not normally shared, with almost all staff we spoke to unaware of any incidents across the trust or on other wards which might have resulted in learning.

There was limited evidence that changes had been made as a result of feedback. When asked, staff were unable to give any examples of any learning from incidents in the past 12 months. Following our inspection, we asked the trust to provide examples of shared learning, however nothing was provided in relation to the wards we visited.

Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation if and when things went wrong. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reason able support to the person. Staff said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. Staff were familiar with the terminology used to describe their responsibilities regarding the duty of candour regulation. Staff described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the patient and their relatives.

Is the service effective?

Competent staff

The service made sure staff were competent for their roles.

The clinical educators supported the learning and development needs of staff. Staff told us there was an emphasis on falls training, and that some face to face training had been delivered in 2020 in addition to the mandatory e learning training. For some of the specialist equipment including the air patient lift, training was delivered by the clinical educator. Staff were assessed to check their competency when operating equipment following their training.

Managers made sure staff attended team meetings or had access to minutes when they could not attend. Staff told us team meetings for all wards were held quarterly, and that minutes were made available for those who could not attend.

Managers identified training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received specialist training for their role. All staff were expected to complete mandatory training modules, and compliance was monitored by managers. Staff told us their training and development needs were discussed at their annual appraisal, and they confirmed they had been assessed to ensure they were competent in their role. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education by their manager.

Staff told us they had undertaken training on falls management, manual handling, dementia awareness and mental capacity whilst at the trust. Staff new to the trust completed this as part of induction training, whereas longer serving staff undertook refresher training. Staff reported that the majority of this training was electronic; however, some modules were delivered face to face.

Multidisciplinary Working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. During our inspection, we observed staff including physiotherapists and occupational therapists work closely with ward staff to provide treatment and support. The therapists collaborated on falls risk assessments with ward staff. Staff told us that they worked well with therapy staff, and regularly shared information such as at daily handover meetings or when therapy teams attended the ward to work with patients.

A trust falls group which was made up of a multi-disciplinary team worked across the trust to develop consistency in working practices, to review falls incidents, provide support and conduct analysis of falls to promote learning. Very few staff we spoke to were aware of the falls group and what they did and were unable to give any examples of sharing learning around falls prevention.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national legislation to gain patients' consent. However, staff did not always undertake mental capacity assessments in line with the Mental Capacity Act. Staff did not consistently follow the Mental Capacity Act requirements when patients were deprived of their liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance, and clearly recorded consent in the patients' records. During our inspection, we observed staff gaining verbal consent when they undertook routine tasks such as administering medicines, taking bloods, shutting curtains around the bed and when delivery therapy. Staff told us they routinely took consent and provided patients with information and answered any questions they may have.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care, however this was not always done in line with the requirements of the Mental Capacity Act.

During our inspection, we identified a patient who had a bed rails risk assessment completed which stated they required the use of bed rails as they were a falls risk and were under one-to-one constant supervision. Documentation within their medical record also stated that the patient lacked mental capacity to be able to consent to decisions about their care and treatment. However, this was not recorded as part of a formal mental capacity assessment and there was no evidence of a capacity assessment having been completed. As the patient was informally recorded as lacking capacity it

would be expected that a formal assessment was completed following the decision to use bedrails. The use of bed rails can be a deprivation of liberty if using them would restrict a patient from easily leaving their bed. As such a DOLS application should be considered if following a mental capacity assessment, this shows a patient does not have the capacity to consent to this restrictive measure.

This concern was raised with the trust executive team after the inspection. The trust provided a response that stated the use of bedrails or having one-to-one support, in and of themselves, does not necessarily constitute a DOLS in the acute trust setting. However, we were not aware of a DOLS application being considered for this patient.

Not all staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards which was included in the trust's safeguarding module. The trust had three safeguarding training modules for nursing staff which were mandatory, however data provided by the trust following our inspection showed that staff either competed safeguarding level 1 and/or level 3, with no recorded competencies for level 2. Staff on ward 205 and 206 met the 95% trust target for safeguarding level 1 with an overall compliance of 95.4%, however overall compliance for safeguarding level 3 was lower at 73.5%. The was also significant variation between the ward, with staff on ward 205 57.9% compliant, while on ward 206 89.1% of staff were compliant for safeguarding level 3. We noted that across both wards, no staff were identified as being eligible for consent training.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff were able to explain the best interests' decision-making process. They gave examples of when it was recognised that patients needed extra support when consenting to treatment, such as when patients had a learning disability or were living with dementia. Staff told us they involved the patient's relatives and carers to provide further information about the patient's wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient. Where patient's lacked relevant mental capacity during completion of 'ReSPECT' forms, we saw capacity assessments were completed and discussions with family were detailed. Staff told us that medical staff were responsible for completing mental capacity assessments. Senior nurses completed DOLS application forms electronically if required.

Is the service responsive?

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. During our inspection, we observed nursing and medical staff interacting with patients and undertaking ward rounds. While they discussed their physical health needs and conditions, they also reviewed their mental health needs and made adjustments where necessary.

Some wards had recruited a dementia key worker who provided one-to-one care for people living with dementia and confused patients. They provided distraction and performed actives with patients on a one-to-one or cohort basis such as puzzles and other games. Prior to the COVID-19 pandemic, they had organised a cream tea lunch for the patients. Staff we spoke with said the role of dementia key worker was invaluable and were very complimentary of the role and the support they provided to both the patients and ward staff. One ward manager told us they were hoping to recruit another dementia key worker for the ward, as the workload over the previous few months had increased and the support the role provided made a difference.

Some wards were designed to meet the needs of patients living with dementia. During our inspection, we found dementia friendly initiatives made to the environment on some wards. For example, on ward 205 staff had made changes to the day room, which included a fake electric fireplace, antique style chairs with accompanying lamps and other historic memorabilia to make patients feel more comfortable. Staff told us that as patients would always be assisted to the toilets, there was no need to help identify them with brightly coloured doors for example.

Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports which enabled staff to provide individualised care to patients. We saw several examples of these fully completed during our inspection. Patient passports included information about patients' likes and dislikes, eating and drinking preferences, special requirements and personal information such as what the patient enjoyed doing in their spare time and information about their family and pets. Communication requirements and preferences were also documented.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust wide enhanced care team provided staff for one-to-one observation. The team included activity co-ordinators who could work with patients to provide distraction activities and reduce the risk of falls.

Staff had access to communication aids to help patients become partners in their care and treatment, and managers made sure staff patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to appropriate translation services, and sign language interpreters when required. Staff had access to a telephone interpreter if they could not attend the ward at short notice. Staff told us they had not experience any difficulties with accessing interpreters when they were needed.

Is the service well-led?

Governance

Governance processes were not yet consistent across the wards. Not all staff received updates and information following incidents and most were unaware of quality improvement initiatives. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers and leaders of the service described the systems and processes of accountability across the wards we visited. Staff understood their roles and what they were accountable for. Nursing staff told us they attended daily huddles to discuss patients most at risk, and we saw that information was available for staff to read across ward areas. This included a trust wide falls policy, which was in date and comprehensive. The trust also had an enhanced nursing policy, which at the time of our inspection was out of date and was due for review in 2018. The policy contained information on patient supervision and monitoring falls risk patients.

However, while staff told us they generally heard about complaints and audits, they were not aware of any incidents that had occurred on the ward or elsewhere across the trust. Staff were also not aware of any quality improvement initiatives. Senior nurses told us that incident investigations and learning from falls was shared with staff via email bulletins and discussed at daily huddles and during handover. Similarly, senior nurses said information from the trust wide falls group was shared during quarterly team meetings. This conflicted with information given to us by staff, who when asked were unable to give any examples of when a fall had occurred, including some staff on one ward we visited where a fall had happened two weeks prior to our inspection. Staff were also unable to give examples, except for one staff member, of learning from falls and any changes made as a result.

Falls were monitored by the trust wide falls group and through regular audits. Following our inspection, the trust sent us a report presented at the patient safety committee, which monitored falls which had occurred across the trust between January and April 2020. Falls data was also included from the previous eight months (April 2019 to December 2019). Between April 2019 and April 2020, the number of falls across Royal Derby Hospital was above the trust target (five falls per 1000 bed days) for 11 of the 13 months reviewed, with a recent increase in the number of falls recorded in March and April 2020. The report also presented data on the number of falls with harm across the trust. At Royal Derby Hospital the harm per 1000 bed days ranged between 0.096 and 0.215 which was below the target.

Several themes were identified in the report in relation to seven reported falls with harm, which included most falls being unwitnessed, confusion in two patients, most of the patients that fell were mobilising, therefore did not fall from their beds and the use of the inflatable device used to lift a patient after a fall was inconsistent. Bed rails were not found to be a significant factor. It is acknowledged that the trust falls group had not been able to meet regularly and suspended meetings in March and April 2020 as part of the COVID-19 trust response.

Information provided by the trust showed various areas of continued improvement and development. These included a renewed focus on delivering falls training to all staff across the trust, a twice yearly falls conference, a ‘falls week’ to be held once a year, the development and using posters to promote falls awareness in clinical areas.

Management of risks, issues and performance

Many actions taken to reduce falls were in progress, with some delayed due to COVID-19. However, leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had arrangements for identifying, recording and manging risks, and staff had opportunities to learn from the performance of the service. However, not all staff we spoke to were aware of any quality improvement project.

The trust falls group was made up of a multi-disciplinary team worked across the trust to develop consistency in working practices and included staff from ward areas and the trusts leadership team. The group were undertaking trust wide quality improvement initiatives and we saw evidence to show that medication reviews and the effectiveness of lying/ standing blood pressure monitoring were being explored for example. Following our inspection, we received the trust wide falls action plan to improve patient safety in relation to falls. The action plan included 18 actions grouped into themes such as policy and procedure, training and patient and staff information. We noted that few actions had been completed, with some delayed due to the COVID-19 pandemic.

The action plan included several measures aimed at addressing some of the concerns we found during our inspection. For example, data provided by the trust showed training compliance for several falls related mandatory training modules was low, and in some cases significantly below the trust target of 95%. One action was to include falls compliance on the workforce dashboard for monitoring and for training reports to be reviewed by the falls group. Wards were also to be identified as priority for receiving extra training. Staff we spoke to on the wards we visited were not aware if they have been identified as a priority area for training.

Another action identified was to ensure ‘falls heroes’ were in place on each ward who would also be members of the falls group. During our inspection none of the wards we visited had falls champions or individuals who were part of the falls group, however the action plan showed this was still outstanding.

One action included falls conferences to be held twice a year and a ‘falls week’ to run annually on each site to raise awareness about falls. Staff told us events scheduled for March were cancelled due to COVID-19 and were due to be rearranged

Senior nurses told us they undertook spot checks of falls assessments, care plans, bed rails and falls checklists. Senior nurses conducted audits to monitor compliance to falls prevention standards.

Surgery

Serious incidents involving falls with harm were discussed at the patient safety group meetings via information presented by the falls group. Areas for improvement and ideas to maintain consistency across the trust were also discussed.

Areas for improvement

The trust must:

Ensure that staff adhere to the Mental Capacity Act 2005 and undertake timely assessments of patients' capacity to consent to care and treatment where it is likely a patient may lack capacity. Staff must also ensure they consider a Deprivation of Liberty Safeguard application where they are restricting a patient for non-urgent care or treatment. Health and Social Care Act (2014) Regulation 11: Need for Consent

Ensure learning following incidents is shared with all staff and embedded. Health and Social Care Act (2014) Regulation 12: Safe care and treatment

The trust should:

Ensure that staff receive training to safely operate equipment

Ensure mandatory training compliance meets the trust target.

Ensure all relevant staff adhere to recommendations following bedrail assessments for patients that are not able to consent.

Ensure that policies and procedures are in date and regularly reviewed.

Our inspection team

The CQC inspection team at Royal Derby Hospital comprised of two CQC Inspectors. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment